# ICD-9-CM Coordination and Maintenance Committee Meeting

## Volumes 1 and 2, Diagnosis Presentations

## May 11, 2000

## SUMMARY

Below is a summary of the diagnosis presentations from the May 11, 2000 ICD-9-CM Coordination and Maintenance Committee Meeting. Comments on this meeting's topics must be received in writing or via e-mail by January 7, 2001. Both the NCHS address and e-mail addresses of C&M staff are listed below. HCFA prepares a separate summary of the meeting for procedures issues.

The next meeting of the ICD-9-CM Coordination and Maintenance Committee is scheduled to be held Friday, November 17,2000 at the Health Care Financing Administration building, Baltimore, MD. Modification proposals for the November 2000 meeting must be received no later than September 17, 2000.

Thank you for your participation in these public forums on the ICD-9-CM. Your comments help insure a more timely and accurate classification.

ICD-9-CM Coordination and Maintenance Committee Meeting
ICD-9-CM Volume 1 and 2, Diagnosis Presentations
May 11, 2000

Mailing Address:

National Center for Health Statistics
ICD-9-CM Coordination and Maintenance Committee
6525 Belcrest Road, Room 1100
Hyattsville, Maryland 20782

Fax: (301)458-4022

Donna Pickett: Room 1100 (301) 458-4200
E-mail: dfp4@cdc.gov

Amy Blum: Room 1100 (301) 458-4200
E-mail: alb8@cdc.gov

David Berglund: Room 1100 (301)458-4200
E-mail: zhc2@cdc.gov

Lizabeth Wing: Room 1100 (301)458-4200
E-mail: llw4@cdc.gov

NCHS Classification of Diseases web page:
http://www.cdc.gov/nchs/icd9.htm

ICD-9-CM Coordination and Maintenance Committee Meeting
ICD-9-CM Volume 1 and 2, Diagnosis Presentations
May 11, 2000

Welcome and Announcements

Donna Pickett welcomed all in attendance to the diagnosis portion of the C&M meeting. She stated that the ICD-9-CM addenda files and conversion table will be on the NCHS web page within the next two weeks. These contain the coding changes which become effective on October 1, 2000. Additionally, AHA Coding Clinic will publish this in a special edition later this year.

NCHS is sponsoring a Data Users Conference in June. Brochures were available for those interested in attending. The conference information is also available on the NCHS home web page (http://www.cdc.gov/nchs).

Donna gave an update on the status of the ICD-10-CM, which is still in development. The final rule for code sets is tentatively scheduled to be published by the end June. After the final rule is published the National Committee on Vital and Health Statistics (NCVHS) will schedule public hearings about moving to new code sets including ICD-10-CM. A more detailed update on ICD-10-CM will be given at the November 2000 ICD-9-CM Coordination and Maintenance Committee meeting. She encouraged everyone to continue to watch the NCHS web page since changes are posted there. Both HCFA and NCHS web pages cross link to each other and there is also a link to the NCVHS web page.

Donna announced that NCHS will no longer mail out the tentative agenda for these meetings because many mailings are returned undeliverable. The agenda is published in the Federal Register and is posted on the NCHS web page. If there is anyone who does not have access to either of these they can contact NCHS so that an agenda can be mailed.

Continuing Education certificates were made available at the conclusion of the meeting.

ICD-9-CM Coordination and Maintenance Committee Meeting
ICD-9-CM Volume 1 and 2, Diagnosis Presentations
May 11, 2000

SUMMARY OF COMMENTS AND DISCUSSION OF VOLUMES 1 AND 2 TOPICS

The following topics were presented at the meeting (see attached topic packet):

Dysmetabolic Syndrome X

Richard Dickey, M.D., representing the American Association of Clinical Endocrinologists (AACE) presented an overview of this syndrome. He stated that it is still an "evolving" syndrome and the definition has changed over time. Currently the AACE defines this syndrome as an increased cellular resistance to insulin. He spoke about the other conditions which are associated with this syndrome and why they were proposing nine new codes (option 2 of the topic). Dr. Dickey recommended disregarding Option 3 (assigning this to hyperinsulinemia) since the term hyperinsulinemia is generally used to mean cases with hypoglycemia. An explanation was also given for the difference between this and cardiac Syndrome X (currently indexed to 413.9).

Several questions were raised regarding how this syndrome would be documented in the medical record and how coders would know to link Syndrome X and the listed associated conditions (e.g., hypertension) to use the codes for this syndrome with those conditions. Dr. Dickey stated that currently physicians are more likely to document this as "insulin resistance" rather than Syndrome X and list associated conditions separately. Many commented that this would be difficult to know when to use the Syndrome X codes especially those which associate it with other conditions. They felt that proposed code 277.79, Other dysmetabolic Syndrome X, would be the most used.

SLAP lesions

There was a question as to whether any other lesions could be assigned to this code. The answer was no. There was a comment that the acronym SLAP and the code description do not match and thought this would cause confusion. Both SLAP and the code title would be included in the index.

Supraglottitis
A question was asked whether to code epiglottitis if this is documented but the physician also writes supraglottitis. In this case the epiglottitis codes would be used since it is more specific.

Stress fracture
A question was raised as to why more sites were not listed with individual codes since codes 733.93-733.98 are available and the proposal only includes new codes 733.93-733.95. This will be reviewed further. Some questioned whether documentation would be clear regarding pathological fracture vs. stress fracture.

Periventricular leukomalacia (PVL)
Laura Powers, M.D., representing the American Academy of Neurology, presented an overview of this condition. Periventricular leukomalacia (PVL) can be caused by hypoxia but intrauterine infections can also cause this. It occurs in both pre-term and full term infants with 25-40% of pre-term infants having it discovered through MRI. 82% of infants having this diagnosed via MRI develop cerebral palsy as well as other chronic sequelae (diplegia, quadriplegia and epilepsy). Because infants have actively myelinating cells for up to six years they are more prone to this. Many infants who have PVL also have intraventricular hemorrhage though one does not always cause the other.

Dr. Powers was asked whether PVL in newborns is the same as the adult condition “white matter disease” and what codes she uses in her practice for that disease. While they are similar, the adult disease is caused by atherosclerosis and they use the stroke codes. However, physicians should be queried about code assignment when this terminology is used in the record.

Mammographic microcalcification
A comment was made that sometimes pathologists use the phrase “microcalcification of breast tissue” and whether this would be coded to this new code. The new code is proposed to be used only for mammographic microcalcification findings.

Premature menopause

A comment was made that one might confuse when to use the proposed code 256.21, postsurgical ovarian failure vs. the new V code, V45.77, acquired absence of genital organs (to which acquired absence of ovary is indexed). Question was also raised as to whether to code patients with one missing ovary here or to the V code. Comment was also made as to how premature menopause, perimenopause and postmenopause are defined. The American College of OB-GYN (ACOG) has definitions for these conditions. These questions and use of the codes could be clarified in a Coding Clinic article.

Burn from tanning bed

It was pointed out that effects of ultraviolet radiation is indexed to code 990 and that coders may confuse when to use that vs. 692.82. The code 990 is an unspecified category and there are excludes notes for specified adverse effects of radiation (such as dermatitis) which refer the coder to the 692.7-692.8 range. This will be reviewed further to see if any further index changes are needed. A question was asked as to whether the “rule of 9's” should be applied to the proposed code 692.76, sunburn of third degree. The rule of 9's is only used with the 948 category of burn codes and codes from that category would not be used with the sunburn codes.

Posttraumatic wound infections versus complicated open wound

No comments regarding this proposal.

Head injuries

No comments regarding this proposal other than bullet wounds should be treated (coded) as skull fractures.

“Fall” versus “Strike against” external cause

A comment was made that the late effect of falls code should be modified as well. A question was raised regarding which proposed “striking against” E code to use if it was not known if the person fell or not. The default would be the striking incident without fall if the documentation was not specific. Current coding guidelines state to use the E code most related to the principal diagnosis and this would not change with these new proposed codes.

ICD-9-CM Coordination and Maintenance Committee Meeting
ICD-9-CM Volume 1 and 2, Diagnosis Presentations
May 11, 2000

Addenda

There were comments regarding the proposed tabular and index changes to add “chiropractic subluxation.” Some thought this sounded like a condition caused by chiropractic care. Others weren’t familiar with the phrase being used by chiropractors. This request came from a chiropractor. The term subluxation is currently indexed to the orthopedist dislocation codes (830-839). One person recommended adding language that would indicate subluxation as diagnosed and treated by a chiropractor. A recommendation was made to contact the ACA (American Chiropractic Association) regarding this terminology and its use.